Teen Clinic
Client Satisfaction Survey

We would like your feedback on the services you received today at (**INSERT NAME OF YOUR CLINIC**). Please answer each of the questions below and return it to (**INSERT NAME OF PERSON TO COLLECT SURVEY**). Please ***do not*** put your name on the survey. Thank you.

1. How did you hear about this clinic? (Check all that apply.)

- ❑ Talking to someone who works at the clinic
- ❑ From a presentation
- ❑ At a program for teens
- ❑ Doctor or nurse
- ❑ Friends
- ❑ Family
- ❑ Boyfriend/Girlfriend
- ❑ Advertisement (TV, radio, newspaper, etc.)
- ❑ Flyer or brochure
- ❑ I saw the clinic from the street
- ❑ Health fair
- ❑ Other: _____

2. What type of services did you come for today? (Check all that apply):

- ❑ Pregnancy Testing
- ❑ STI/HIV Screening/Treatment
- ❑ Reproductive Health Education and Counseling
- ❑ Birth Control Method Education and Counseling
- ❑ Birth Control Method Management
- ❑ Gynecological Problems
- ❑ Breast Exam/Testicular Exam
- ❑ Reproductive Health Exam, Including Pap Smear
- ❑ Emergency Contraception
- ❑ Other, specify: _____

3. Did you get the Services you came for?

Yes	**No**
1	2

If no, please explain.

4. How comfortable did you feel talking with clinic staff?

Not at all comfortable	**Not very comfortable**	**Neutral**	**A little comfortable**	**Very comfortable**
1	2	3	4	5

5. Overall, I think the clinic staff were:

Not at all helpful	**Not very helpful**	**Neutral**	**A little helpful**	**Very helpful**
1	2	3	4	5

6. What do you like most about this clinic?

7. What do you think could be done to improve the services here?